This is only a summary. **Due to the Short Plan Year coverage period (so the State can change to a calendar year), all deductibles and out-of-pocket limits are cut in half to accommodate the six month timeframe.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.dbm.maryland.gov/benefits or by calling 410-767-4775 or 1-800-307-8283.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	None	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No	This plan covers most services provided in network in full; your only out of pocket costs are copayments.
What is not included in the out–of–pocket limit?	Not applicable for this plan	Not applicable most services are covered at 100% after a copay for in-network services.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers visit www.carefirst.com/statemd or call 800-225-0131.	If you use an in-network doctor or other healthcare **provider**, this plan will pay some or all of the costs of covered services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see any in-network **specialist** you choose without permission from this plan. There is no coverage for services received out-of-network under this plan except services for a true medical emergency.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 410-767-4775 or 1-800-307-8283 or email us at EBDMAIL@dbm.state.md.us or visit us at www.dbm.maryland.gov/benefits
If you aren't clear about any of the bolded & underlined terms used in this form, see the Glossary at www.dbm.maryland.gov/benefits

- **Copayments** (copays) are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the **plan**'s **allowed amount** for an overnight in-network hospital stay is $1,000, the cost would be covered in full since this **plan** does not require **coinsurance**.
- This **plan** requires you to use in-network **providers** and requires only the payment of **copayments**.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	You must pay all charges billed by provider.	none
	Specialist visit	$30 copay	You must pay all charges billed by provider.	none
	Other practitioner office visit	No charge for Chiropractic & Acupuncture Services	You must pay the all charges billed by provider.	Acupuncture is only covered for chronic pain management. Preauthorization required.
	Preventive care/screening/immunization	No Charge	You must pay all charges billed by provider.	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	You must pay all charges billed by provider.	none
	Imaging (CT/PET scans, MRIs)	No Charge	You must pay all charges billed by provider.	none

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or by calling 1-877-213-3867.	Generic drugs	$10 copay (1-45 day supply); $20 copay (46-90 day supply)	You must pay all charges billed by provider.	**Outpatient Prescription Drug coverage is not included in your medical plan.** You elect this coverage separately from your medical plan. The plan is administered by Express Scripts; you receive a separate ID card and pay a separate premium for prescription coverage. Review the State of Maryland's website at www.dbm.maryland/benefits for more details.
	Preferred brand drugs	$25 copay (1-45 day supply); $50 copay (46-90 day supply)	You must pay all charges billed by provider.	
	Non-preferred brand drugs	$40 copay (1-45 day supply); $80 copay (46-90 day supply)	You must pay all charges billed by provider.	
	Specialty drugs	Copay and drug supply limit varies by type of drug.	You must pay all charges billed by provider.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	You must pay all charges billed by provider.	Must be preauthorized by plan.
	Physician/surgeon fees	No Charge	You must pay all charges billed by provider.	Must be preauthorized by plan.
If you need immediate medical attention	Emergency room services	Facility: $75 copay Physician: $75 copay	Facility: $75 copay Physician: $75 copay	Copay waived if admitted. If criteria are not met for a medical emergency, the plan coverage is 50% after copays.
	Emergency medical transportation	No Charge	No Charge	——————none——————
	Urgent care center	$30 copay	You must pay all charges billed by provider.	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	You must pay all charges billed by provider.	Preauthorization required 20% non-compliance penalty
	Physician/surgeon fee	No Charge	You must pay all charges billed by provider.	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office: $15 copay	You must pay all charges billed by provider.	——————none——————
	Mental/Behavioral health inpatient services	No Charge	You must pay all charges billed by provider.	Preauthorization required. If not obtained you are responsible for all costs.
	Substance use disorder outpatient services	Office: $15 copay	You must pay all charges billed by provider.	——————none——————
	Substance use disorder inpatient services	No Charge	You must pay all charges billed by provider.	Preauthorization required. If not obtained you are responsible for all costs.
If you are pregnant	Prenatal and postnatal care	No Charge	You must pay all charges billed by provider.	Additional copays or preauthorization requirements may apply to postnatal care.
	Delivery and all inpatient services	No Charge	You must pay all charges billed by provider.	——————none——————
If you need help recovering or have other special health needs	Home healthcare	No Charge	You must pay all charges billed by provider.	Limited to 120 days per plan year.
	Rehabilitative services	$30 copay per visit	You must pay all charges billed by provider.	Limited to 50 combined visits per plan year for Speech, Occupational, and Physical Therapy. Must be preauthorized by plan.
	Habilitative services	$30 copay per visit	You must pay all charges billed by provider.	No limit of treatment for children under 19 with congenital or genetic birth defects including autism, autism spectrum disorder, and cerebral palsy. Must be preauthorized by plan. Over age 19 members visits are limited to 50 combined visits for therapies.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	No Charge	You must pay all charges billed by provider.	Limited to 180 days per plan year. Must be preauthorized by plan.
	Durable medical equipment	No Charge	You must pay all charges billed by provider.	Preauthorization required if over $1,000.
	Hospice service	No Charge	You must pay all charges billed by provider.	Must be preauthorized by plan.
If your child needs dental or eye care	Eye exam	No charge - Up to a maximum of $45	You must pay all charges billed by provider.	Coverage is limited to one routine eye exam per plan year up to $45. Non-routine eye exam copay is $15 per visit.
	Glasses	Refer to your contract or the online Benefits Guide for coverage details.	Refer to your contract or the online Benefits Guide for coverage details.	Frames: Plan pays $45 once per plan year; member pays balance.
	Dental check-up	Covered under separate dental plan. Two types are offered: dental HMO and dental PPO	Out-of-network coverage available under the DPPO plan only.	Dental benefits are administered by United Concordia; you receive a separate ID card and pay a separate premium for dental coverage. **You must enroll in one of the dental plans to have dental coverage.** For more information call United Concordia at 1-888-638-3384 or www.unitedconcordia.com/statemd.

Excluded Services & Other Covered Services:

Services Your Medical Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Routine Dental care (Adult/Child)
- Long-term care
- Weight loss programs (Nutritional counseling is covered)
- Outpatient prescription drug
- Routine foot care

Other Covered Medical Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Immunization & preventative screenings (covered in full in-network only)
- Bariatric surgery
- Home healthcare
- Hearing aids covered once every 36 months with limitations
- Infertility Treatment – Artificial insemination and In vitro. Infertility treatment limited to 3 attempts, not to exceed a $100,000 lifetime maximum. Other restrictions apply. Refer to your policy and plan documents or the online benefits guide.

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Employee Benefits Division at 1-800-307-8283. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Employee Benefits Division at 410-767-4775, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, the Office of Health Insurance Consumer Assistance can help you file an **appeal**. Contact information: 1-877-261-8807; heau@oag.state.md.us; or http://www.oag.state.md.us/Consumer/HEAU.htm

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Medical Copayment	$0
Prescription Copayment	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,770
- **Patient pays** $630

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Medical Copayment	$150
Prescription Copayment	$400
Coinsurance	$0
Limits or exclusions	$80
Total	**$630**

The coverage examples are based on the experience of one covered member or dependent regardless of coverage level.

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as flexible spending accounts (FSAs) that help you pay out-of-pocket expenses.